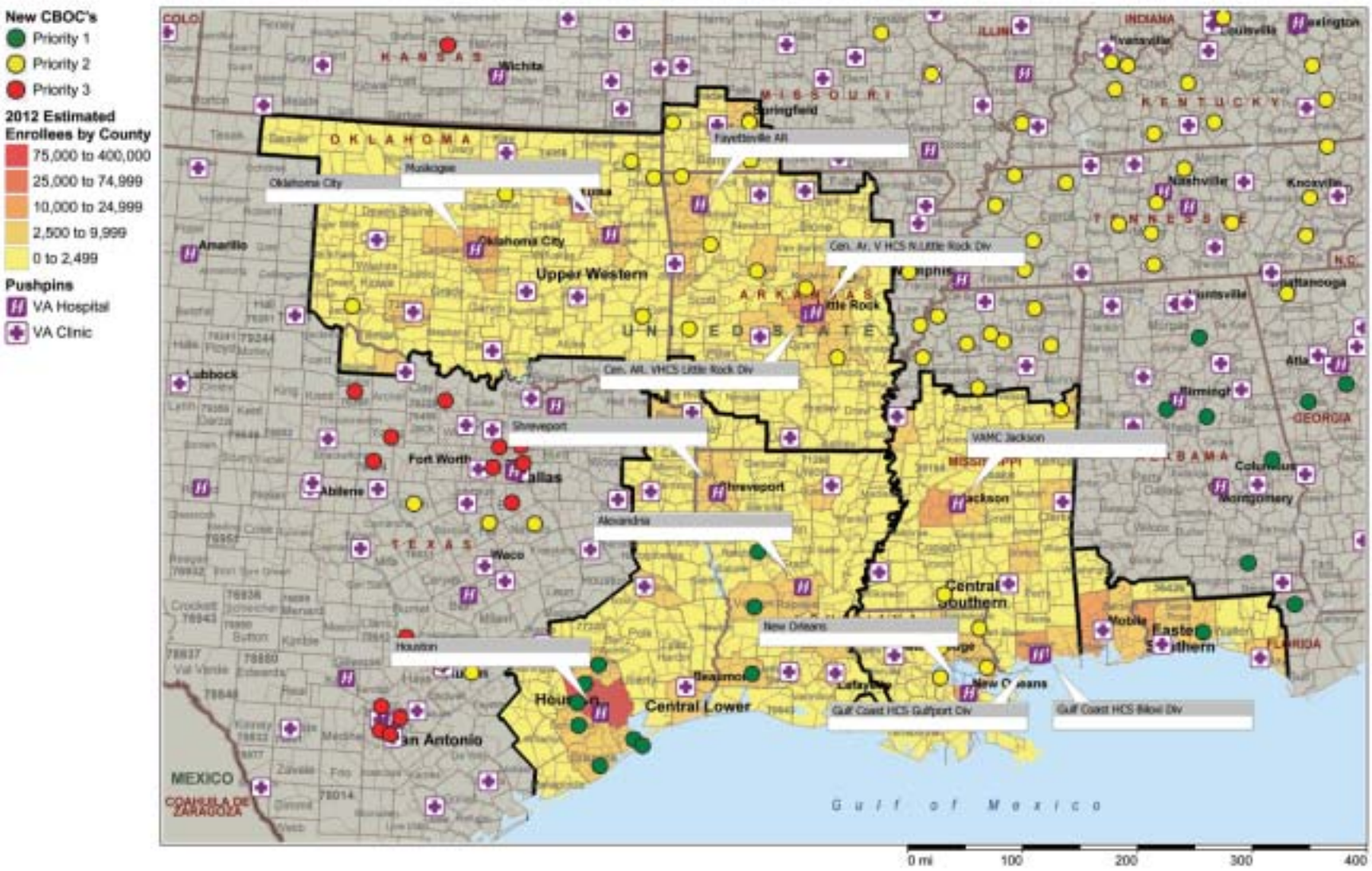
VISN 16 – South Central VA Health Care Network



VISN 16, South Central VA Health Care Network

VISN Overview

VISN 16, South Central VA Health Care Network, is an integrated, comprehensive health care system that provided health care services to 382,000 of the 574,000 veterans enrolled in VA's health care system in FY 2003.[338] Geographically, this VISN spans nearly 170,000 square miles.

With a VA staff of 14,869 FTEs,[339] VISN 16 delivers health care services through ten medical centers, 30 CBOCs, seven nursing homes, and two domiciliary units. Additionally, VA operates 11 Vet Centers in VISN 16's catchment area. The VISN includes all or part of Florida, Alabama, Mississippi, Louisiana, Arkansas, Missouri, Oklahoma, and Texas.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for the veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify levels of need for services in VISN 16.

VISN 16	FY 2001	FY 2012	FY 2022
Enrollees	482,234	543,624	510,862
Veteran Population	1,917,259	1,670,716	1,459,861
Market Penetration	25.15%	32.54%	34.99%

For the CARES process, VISN 16 was divided into four markets: Central Lower Market (*facilities:* Houston, TX, and Alexandria and Shreveport, LA); Central Southern Market (*facilities:* New Orleans, LA, and Jackson, Gulfport, and Biloxi, MS); Upper Western Market (*facilities:* Oklahoma City and Muskogee, OK, and Fayetteville, Little Rock, and North Little Rock, AR); Eastern Southern Market (*facilities:* none).

[338] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[339] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited five sites and conducted three public hearings in VISN 16. The Commission received 3,090 comments regarding VISN 16.

- *Site Visits:* Biloxi and Gulfport on July 2; Muskogee on July 22; and Little Rock and North Little Rock on September 3.
- *Hearings:* Muskogee on August 22; Biloxi on August 26; and Shreveport on August 27.

Summary of CARES Commission Recommendations

I Consolidation/Realignment – Gulfport

1. The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life cycle cost analysis for the Gulfport campus.
2. The Commission recommends that there be a clear commitment from DoD for the utilization of Keesler Air Force Base (AFB) as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing health services.
3. The Commission concurs with the DNCP proposal to develop enhanced use lease (EUL) opportunities at Gulfport.
4. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-237)

II Small Facility – Muskogee

1. The Commission concurs with the DNCP proposal to maintain the inpatient medicine program at Muskogee. The Commission recommends that a more thorough study be conducted of meeting health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. A decision to expand inpatient psychiatry should consider results of the study.

2 The Commission concurs with the DNCP proposal to close inpatient surgery and ICU beds at Muskogee and that ambulatory surgery should continue with surgery observation beds available.

(see page 5-240)

III Inpatient Care and VA/DoD Sharing

1 The Commission concurs with the DNCP proposal regarding VA/DoD sharing in the Eastern Southern Market with Pensacola Naval Hospital and Eglin AFB to provide inpatient services.

2 The Commission recommends contracting in the community to ensure essential inpatient care in the underserved Eastern Southern Market.

3 The Commission recommends that:

- a Before taking action to alter existing VA services, VA must ensure there are viable alternatives in the community.
- b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as having the availability of trained staff to negotiate cost-effective contracts.

4 The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care from veterans in the Florida Panhandle.

(see page 5-243)

IV Outpatient Care

1 The Commission concurs with the DNCP proposals to add CBOCs in VISN 16 to resolve access to primary care gaps as well as gaps in capacity to meet demand for outpatient services.

2 The Commission recommends that:[340]

- a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
- b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
- c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

[340] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-245)

V Special Disability Programs – Blind Rehabilitation Center

1 The Commission concurs with the DNCP proposal to establish a blind rehabilitation center (BRC) in Biloxi. The Commission recommends further analysis to determine the size of the center.

(see page 5-248)

VI Special Disability Programs – Spinal Cord Injury Center

1 The Commission concurs with the DNCP proposal to establish a 30-bed Spinal Cord Injury (SCI) Center in VISN 16, but does not concur with locating it at North Little Rock.

2 The Commission recommends that VA further study where an SCI Center should be located, taking into consideration referral patterns and excess capacity at the closest SCI Centers.

(see page 5-249)

VII Excess VA Property

1 The Commission concurs with the DNCP proposal for an EUL cooperative arrangement to construct a high-rise medical arts building at the Houston VAMC.

2 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-250)

Consolidation/Realignment – Gulfport

DNCP Proposal

"Gulfport's current patient care services will be transferred to the Biloxi campus and possibly Keesler AFB. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility or other compatible uses to benefit veterans. Any revenues or in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Close Gulfport division and enter into an enhanced use leasing agreement for the majority of the property. Enter into a sharing agreement for provision of clinical services with Keesler Air Force Base.
3. *Alternative 1:* Close Gulfport division and enter into an EUL for the majority of the property. Construct new facilities at Biloxi to accommodate patient workload from Gulfport and Keesler AFB, and new expanded programs from the CARES planning initiatives.
4. *Alternative 2:* Close Gulfport and enter into an EUL agreement for the majority of the property. Enter into a sharing agreement for provision of clinical services with Keesler AFB. Additional space will be provided at Biloxi via minor and nonrecurring maintenance (NRM) construction.

Commission Analysis

The Gulfport and Biloxi VAMCs are located eight miles apart, and their services have been consolidated for more than 30 years. The DNCP would provide for additional consolidation of inpatient care by maximizing the use of vacant space at Biloxi to construct new facilities to absorb Gulfport's inpatient workload. Further, because of the close proximity of the two campuses and the enhanced services, neither veterans, veterans' families, nor VA employees would be negatively impacted.[341]

Services at the Biloxi VAMC consist of 45 internal medicine beds (average daily census [ADC] 33), 12 surgery beds (ADC 8), a 171-bed domiciliary facility (ADC 148), 104 nursing home beds (ADC 99), and 20 intermediate care beds (ADC 18). Additionally, the Biloxi VAMC provides outpatient primary, specialty care, and mental health services.[342]

[341] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 16.
[342] VSSC KLF Menu Database, *Bed Control, Occupancy Rates,* and *CBOC Workload and VAST Report*.

Services at the Gulfport VAMC consist of 144 inpatient psychiatry beds (ADC 67) and 56 nursing home beds (ADC 48). Outpatient primary, specialty care, and mental health services are provided as well.[343]

The Gulfport campus encompasses approximately 90 acres, 50 of which are desirable beachfront property. While touring the Gulfport campus in July, Commissioners learned that many buildings are of historical significance. However, they also learned that many of these historic buildings are vacant or used only for storage. The VISN's market plan includes long-term EUL agreements that would preserve these historic buildings but provide for appropriate reuse of the grounds.

Keesler AFB is likewise only a few miles from the Gulfport VAMC and actually abuts the Biloxi VAMC. Presently, VA provides inpatient psychiatric health care to Keesler's active duty military personnel with non-adjustment/stress-type mental health illnesses. During the Commission's site visit in July, Brigadier General David Young indicated that his primary goal through collaboration with VA is to support VA's infrastructure by meeting veterans' acute hospitalization, surgery, and rehabilitation needs. In return, General Young would like to engage in joint clinical research with VA as well as joint psychiatric services.

VISN leadership provided testimony that moving to a single facility will have a positive impact on patients at Gulfport. Ms. Julie Cattelier, Director of the VA Gulf Coast Veterans Health Care System, testified:

> We believe that it is most critical to establish a single standard of care for our patients receiving mental health and long-term care, and that means that in the case of a medical crisis…they would receive exactly the same level of care and level of clinical support that any patient in a comprehensive health care system would receive.[344]

According to Dr. Robert Lynch, Director of VISN 16, "Veterans will not lose services. There will be more services here in the Biloxi/Gulfport area than there currently are."[345] Stakeholders at the public hearing and site visits were generally supportive of the consolidation. The proposed timeline for implementing this closure is FY 2009.

The VISN realignment proposal contained a life cycle cost analysis with some inconsistencies, including $44.6 million in new construction and renovation in the 100 Percent Contracting Alternative. If the costs are adjusted to correct for that error, the four alternatives to the Status quo are close in net present value.

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[343] VSSC KLF Menu Database, *Bed Control, Occupancy Rates,* and *CBOC Workload and VAST Report*.

[344] Julie Cattelier, VA Gulf Coast Veterans Health Care System Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 31.

[345] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 16.

The preferred alternative would require $60.5 million in new construction and renovation and would achieve a net present value savings of $436.8 million. Although the net present value in excess of $400 million is cited, the proposal states that enhanced lease revenue of $44 million is expected and cost savings at Gulfport from reductions in staff and operating costs would save another $48 million. Explanations for monetary savings are confusing if non-existent. A more thorough life cycle cost analysis must be completed.[346]

Commission Findings

1. The Gulfport and Biloxi VAMCs are 8 miles apart.
2. The Gulfport Division has 90 acres, 50 of which are desirable beachfront.
3. New construction is needed for Biloxi to absorb Gulfport's workload.
4. The life-cycle cost analysis in the realignment proposal contains inconsistencies.
5. The VISN is currently in discussions with Keesler AFB to assess feasibility of entering into a sharing agreement to resolve space issues at Biloxi.
6. VISN leadership and stakeholders support consolidation.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life-cycle cost analysis for the Gulfport campus.
2. The Commission recommends there be a clear commitment from DoD for the utilization of Keesler AFB as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing DoD and VA health services.
3. The Commission concurs with the DNCP proposal to develop EUL opportunities at Gulfport.
4. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

[346] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

II Small Facility – Muskogee

DNCP Proposal

"Muskogee maintains its inpatient medicine program, with possible expansion of inpatient psychiatry. Inpatient surgery and ICU beds are recommended for closure due to low volume of selected major procedures. Ambulatory surgery would continue with surgery observation beds available."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

Located in the Upper Western Market of VISN 16, the Muskogee VAMC is a primary and secondary level medical center providing services in medicine, surgery, and mental health. The Muskogee VAMC has been in operation since 1923 and has, in recent years, undergone extensive renovations to upgrade inpatient medicine and surgery services and outpatient primary and specialty care services.

The Muskogee VAMC was probably overbuilt. This is evident by 33,709 square feet of vacant space.[347] This situation would be exacerbated if surgical beds were closed vacating an additional 100,000 square feet.

Muskogee's inpatient ADC has been constant at 44. While the total number of patients treated has increased, ADC is projected to decline to 36 in FY 2012, and to 27 in FY 2022.[348]

The Upper Western Market is projected to need 84 additional acute psychiatric beds by FY 2012. Currently, there are ten acute psychiatric beds at the Fayetteville VAMC, 30 acute psychiatric beds at the Oklahoma City VAMC, and 50 acute psychiatric beds at the Little Rock campus. The Muskogee VAMC does not currently have any inpatient acute psychiatry beds.[349]

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[347] Management of CARES Space Report received from the VISN Support Services Center (VSSC) dated September 2, 2003.
[348] Appendix D, *Data Tables*, page D-66.
[349] VSSC KLF Menu Database, *Bed Control, Occupancy Rate.*

Approximately 4,800 patients are provided outpatient mental health services at the Muskogee VAMC and the Tulsa CBOC.[350] The number of mental health patients in the Muskogee/Tulsa area has been increasing steadily in the past few years (e.g., by 10 percent from FY 2001 to FY 2002). When these patients require acute psychiatric hospitalization, they are treated on an emergent basis in private facilities in the Tulsa area or more commonly transported to the Oklahoma City VAMC 140 miles away. The VISN Director testified that an average of five patients in the Oklahoma City VAMC's acute psychiatric unit are from Muskogee/Tulsa. VISN leadership indicated that as part of the proposal to maintain the inpatient program at the Muskogee VAMC, the VISN would reallocate inpatient psychiatry workload to the Muskogee VAMC, which currently does not have inpatient psychiatry.[351]

Inpatient psychiatry workload data for these VAMCs reflect the following: Fayetteville has ten inpatient psychiatry beds. Little Rock has 85 acute and long-term psychiatric beds. In FY 2003, there was a slight ADC increase for Fayetteville to 11. Little Rock had an increase to 72. With operating beds of 39, Oklahoma City's ADC was 37 in FY 2000, 42 in FY 2001, 43 in FY 2002, and 45 in FY 2003.[352] The CARES inpatient psychiatry projection data do not project inpatient bed needs for each facility.[353]

The VISN plans to meet the projected demand for the 84 additional acute inpatient psychiatric beds in the Upper Western Market by increasing the size of the three current units. This is particularly appropriate at Fayetteville, which has experienced a 22.5 percent increase from FY 2001 to FY 2002.[354] The VISN also plans to establish a new, small acute inpatient psychiatric unit at the Muskogee VAMC. This would provide easier access for the growing population in the Muskogee/Tulsa area. While the Muskogee unit would be small, it would be similar to Fayetteville.

The VISN Director indicated that Muskogee's current inpatient space, which was configured for medical/surgical units, is not properly set up to handle psychiatric patients. Minor renovations would be required.

There are 12 non-VA, JCAHO-accredited medical facilities within 60 minutes of the Muskogee VAMC. Six offer inpatient psychiatric care and have excess capacity.

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[350] VSSC KLF Menu Database, *CBOC Patients Receiving Mental Health Services*.

[351] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Muskogee, OK, Hearing on August 22, 2003, page 18.

[352] VSSC KLF Menu Database, *Bed Control, Occupancy Rate*.

[353] VSSC CARES Portal, VISN 16 Analysis: Psychiatry Inpatient Needs in the Upper Western Market, South Central VA Health Care Network.

[354] Department of Veterans Affairs National Mental Health Performance Monitoring System, FY 2002 Report (Table 5.7).

At the Muskogee hearing, Commissioners and witnesses discussed the growing veteran population in Tulsa. The Tulsa CBOC provided services to 14,255 patients in FY 2003, approximately half of the patients seen at the outpatient clinic at Muskogee VAMC and its other CBOC in McAlester, OK.[355] The Commission discussed that a hospital in Tulsa would be ideal. However, the Muskogee facility provides inpatient care for the Tulsa population. If the Muskogee inpatient services were closed, the next nearest VAMC is Oklahoma City, 140 miles away.

Commission Findings

1. The Muskogee VAMC has been underutilized.
2. Muskogee has significant vacant space, and closing surgical beds would increase the amount of vacant space.
3. Muskogee's inpatient workload has been constant for the past few years. Medicine workload projections indicate that 36 beds would be needed in FY 2012 and 27 beds would be needed in FY 2022.
4. There are 12 non-VA, JCAHO-accredited medical facilities within 60 minutes of the Muskogee VAMC. Six offer psychiatric care and have excess capacity.
5. Adding a small inpatient psychiatry unit at the Muskogee VAMC would be a reasonable part of a broader plan to increase inpatient psychiatry capacity in the Upper Western Market to meet projected demand for 84 additional beds by FY 2012.
6. Renovations would be needed at the Muskogee VAMC and the other three medical centers in the Upper Western Market to accommodate increases in inpatient psychiatry workload.
7. Tulsa is the second largest veteran catchment area in the Upper Western Market and VA operates a Tulsa CBOC. This CBOC and Muskogee facilities provide outpatient mental health services to approximately 4,800 patients annually. When these patients require acute inpatient psychiatry care, they are hospitalized in Tulsa under contracted care or are transported to the Oklahoma City VAMC 140 miles away.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to maintain the inpatient medicine program at Muskogee. The Commission recommends that a more thorough study be conducted of meeting

[355] VSSC KLF Menu Database, *CBOC Workload and VAST Data*.

health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. A decision to expand inpatient psychiatry should consider results of the study.

2 The Commission concurs with the DNCP proposal to close inpatient surgery and ICU beds at Muskogee and that ambulatory surgery should continue with surgery observation beds available.

III Inpatient Care and VA/DoD Sharing

DNCP Proposal

"The acute hospital gap will be met in Eastern Southern market through a sharing agreement with Eglin AFB, adding a point of care in Panama City, continued contracting with the University of South Alabama in Mobile and expanding services currently provided by Pensacola Naval Hospital via a joint venture."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Eastern Southern Market is the only market in VISN 16 without a VA medical center. Only four percent of the veterans in this market meet the CARES hospital access criteria. The requirement is 65 percent.[356] Geographically, this market area includes the western portion of the Florida Panhandle. The eastern portion of the Panhandle is in VISN 8 and is also experiencing gaps in access to hospital care. Both the VISN 16 and 8 leaderships testified as to the need to address access to hospital care in this area.[357]

VISN 16 hearing testimony and access data highlight the underserved nature of this population and the importance of continuing to partner with the DoD on inpatient care. Congressman Jeff Miller testified, "Florida's First Congressional District represents what is arguably the most striking example of access to care challenges in the nation. … I am pleased that CARES recognizes the Federal medicine partnering opportunities that already exist…and the potential savings through sharing by the expansion of current agreements."[358]

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[356] VISN 16, CARES Market Plan, submitted April 15, 2003.

[357] For more information on the Panhandle of Florida, please see the report on VISN 8.

[358] The Honorable Jeff Miller, Congressman, Written Testimony submitted at the Biloxi, MS, Hearing on August 26, 2003 page 1, available from [*http://www.carescommission.va.gov/Documents/BiloxiPanel3.pdf*].

During the Commission's site visit to Biloxi and Gulfport, stakeholders shared their concerns about the distances veterans in the Eastern Southern Market must travel to receive VA care. VISN leadership indicated that inpatient care of veterans from this market area is provided in Biloxi and Gulfport, unless community-based services are available. This means that some veterans may travel 6 to 8 hours to the nearest VAMC.

Additionally, 13 VA/DoD sharing agreements are in place between the Gulf Coast Veterans Health Care System and six military facilities. More sharing agreements are in various planning stages. Among these is a plan to expand arrangements with the naval hospital (Correy Station) in Pensacola, Florida. At the time of the Commission's visit, this hospital had 60 beds with an average daily census of 25. In addition to overnight stays, this facility has a large volume of same day surgery and other procedures that occupy their beds.[359] Further, the VISN currently has an agreement with Eglin AFB to provide outpatient primary care. VISN leadership would like to expand this agreement to include inpatient services.[360]

Commission Findings

1. Only 4 percent of veterans living in the Eastern Southern Market meet CARES access standards for inpatient care.
2. The Florida Panhandle is divided between VISNs 16 and 8. Both VISNs have similar gaps in access to hospital care for veterans in the Panhandle.
3. The Eastern Southern Market relies on DoD collaboration and contracting for inpatient care.
4. VISN 16 currently has several sharing agreements with DoD.

Commission Recommendations

1. The Commission concurs with the DNCP proposal regarding VA/DoD sharing in the Eastern Southern Market with Pensacola Naval Hospital and Eglin AFB to provide inpatient services.
2. The Commission recommends contracting in the community to ensure essential inpatient care in the underserved Eastern Southern Market.
3. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

[359] VISN 16, Site Visit Report, Biloxi-Gulfport, July 2, 2003, page 3.
[360] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 19.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

4 The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care from veterans in the Florida Panhandle.

IV Outpatient Care

DNCP Proposals

"*Primary Care* – VISN 16 has a primary care access gap in all four markets and an acute hospital gap as well in the Eastern Southern market.[361] The plan includes as a high implementation priority category, 11 CBOCs for the Eastern Southern and Central Lower markets. The National CARES Plan attempts to balance meeting national access guidelines while ensuring the current and future viability of its acute care infrastructure. Consequently, while new access points in the Upper Western and the Central Southern markets in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Outpatient Services* – Increasing demand for primary care and specialty care in all four markets will be met by the addition of 11 new CBOCs in the Eastern Southern and the Central Lower markets, expansion of existing CBOCs via contract, lease, and new construction. In addition, it will be met by reconfiguration of space at the VAMCs via renovation, conversion of vacant space, and new construction."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Significant gaps were found in access to outpatient primary care in all four markets in VISN 16. In the Upper Western Market area, only 54 percent of veterans met the access to primary care criteria (requirement is 70 percent). The Central Lower Market shows that only 55 percent of veterans met the access criteria. The Eastern Southern Market has a primary care access gap of 60 percent, and the Central Southern Market has a primary care access gap of 58 percent.[362]

[361] The gap in acute hospital care in the Eastern Southern Market is discussed in the Inpatient Access section.
[362] VISN 16, CARES Market Plan, submitted April 15, 2003.

In addition to access for primary care, the CARES workload projections indicate increased demand for outpatient specialty care in all of VISN 16's markets. In the Central Lower Market, outpatient care is projected to increase by 95 percent in FY 2012 and 80 percent in FY 2022. In the Central Southern Market, demand is projected to increase by 100 percent over the FY 2001 baseline in FY 2012, decreasing to 87 percent in FY 2022. For the Eastern Southern Market, demand is projected to be 159 percent over the baseline by FY 2012 and 154 percent in FY 2022. Additionally, the Upper Western Market's demand is projected to be 103 percent in FY 2012, decreasing to 86 percent in FY 2022. These data indicate the increased demand for outpatient specialty care will primarily occur between now and FY 2012.[363]

In response to the primary care access gaps and the increasing demand for specialty services, the VISN proposed adding 16 additional CBOCs, 11 of which are included in the DNCP's priority group one. These are for the Central Lower and the Eastern Southern Markets. The CBOCs slated for the Central Lower Market would accommodate 31,000 new enrollees and would increase access to above 70 percent.[364] Further, one of them would include a joint venture site at Fort Polk.[365] Dr. Robert Lynch, VISN 16 Director, testified, "We are proposing a major clinical addition at the Overton Brooks VA Medical Center in Shreveport" to address the outpatient specialty care in the Central Lower Market.[366] In the Eastern Southern Market, the proposed new CBOCs also would increase access to above 70 percent. VISN leadership anticipates similar enhancements to outpatient care services in the other market areas.[367]

The Commission is concerned that the DNCP fails to address projected workload gaps in outpatient mental health services in VISN 16. In the Eastern Southern Market, there is projected to be a gap of 89 percent by FY 2012 and 63 percent by FY 2022. There are also substantial projected gaps by FYs 2012 and 2022, including in the Central Lower Market (48 and 21 percent, respectively) and the Upper Western Market (42 and 16 percent, respectively), which again are not addressed in the DNCP.[368]

The VISN currently has sharing agreements with DoD to provide primary care services. Agreements exist at Tyndall and Eglin AFBs in Florida, and the VISN would like to establish a CBOC at Eglin AFB.[369]

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[363] Appendix D, *Data Tables*, page D-63.

[364] VSSC CARES Portal, *Access Planning Initiatives for the Central Lower Market.*

[365] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Shreveport, LA, Hearing on August 21, 2003, page 17.

[366] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Shreveport, LA, Hearing on August 21, 2003, page 15.

[367] Robert Lynch, MD, VISN 16 Director, Written Testimony submitted at the Biloxi, MS, Hearing on August 26, 2003, page 3, available from [*http://www.carescommission.va.gov/Documents/BiloxiPanel2pdf*].

[368] Appendix D, *Data Tables*, page D-63.

[369] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 18.

Commission Findings

1. The VISN proposed a total of 16 new CBOCS to resolve gaps in outpatient care services. Eleven CBOCs for the Central Lower and Eastern Southern markets of VISN 16 are in the DNCP's priority group one.
2. The Central Southern and Upper Western markets have access and workload gaps in primary and specialty care, but proposed CBOCs are not in priority group one.
3. A clinical addition is proposed in Shreveport to address increased outpatient specialty care needs in the Central Lower Market.
4. There are large projected gaps in outpatient mental health care, which have not been addressed in the DNCP.
5. The VISN has a sharing agreement with DoD to provide outpatient care to veterans and would like to establish a CBOC at Eglin AFB, Florida.

Commission Recommendations

1. The Commission concurs with the DNCP to add CBOCs in VISN 16 to resolve access to primary care gaps as well as gaps in capacity to meet demand for outpatient services.
2. The Commission recommends that:[370]
   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   e. Whenever feasible, CBOCs provide basic mental health services.
   f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

[370] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

V Special Disability Programs – Blind Rehabilitation Center

DNCP Proposals

"*Appendix A, Executive Summary for VISN 16* – Build a new 20-bed blind rehabilitation center at Biloxi. *Chapter 7: Enhancing Access to Special Disability Programs* – 36-bed blind rehabilitation center in Biloxi."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP sets forth two proposals relating to the number of blind rehabilitation beds recommended for VISN 16. Current estimates indicate that approximately 2,700 veterans who are legally blind are enrolled in VISN 16. CARES data indicate the VISN will need 36 beds for blind patients in FY 2012 and 37 beds in FY 2022. Currently, patients are referred to Birmingham, AL (VISN 7), Tucson, AZ (VISN 18), and Waco, TX (VISN 17), as VISN 16 does not have a BRC. According to the hearing record, the VISN leadership reviewed their referral patterns and expects to continue referring to VISN 17 for veterans residing in the western portion of VISN 16. However, they believe that the balance of veterans in VISN 16 would be better served by a BRC in Biloxi.[371]

Commission Findings

1. VISN 16 does not currently have a BRC.
2. Blind veterans residing in VISN 16 are referred to one of three other VISNs for care.
3. The DNCP indicates that VISN 16 will need 36 beds for blind veterans by FY 2012 and 37 beds by FY 2022.

Commission Recommendation

The Commission concurs with the DNCP proposal to establish a BRC in Biloxi. The Commission recommends further analysis to determine the size of the center.

[371] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing, on August 26, 2003, page 15.

VI Special Disability Programs – Spinal Cord Injury Center

DNCP Proposals

"*Appendix A Executive Summary for VISN 16* – Construct a new 25-bed Spinal Cord Injury (SCI) Center at the Central Arkansas Healthcare System-North Little Rock division. *Appendix Q* – 25 to 34 bed SCIU at North Little Rock."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP sets forth two proposals relating to the number of SCI beds proposed for VISN 16. Appendix Q of the DNCP indicates that VISN plans recommend location of the SCI Center be at North Little Rock. Appendix Q proposes that this location be reconsidered and the VISN's choice justified.

In FY 2001, VISN 16 had 34 acute SCI beds. By FY 2012, acute bed projections indicate 74 beds would be needed, increasing to 90 beds by FY 2022. Further, in FY 2001, VISN 16 had nine long-term care (LTC) SCI beds. Projections indicate that by FY 2012, 128 LTC SCI beds would be needed, increasing to 155 in FY 2022.[372]

According to VISN leadership, North Little Rock was selected as the proposed location for the new SCI Center because this campus has significantly larger grounds and available space. The Commission notes, however, that the North Little Rock Division is not a tertiary care hospital. On the other hand, both the Little Rock Division and the Shreveport VAMC provide tertiary care. The Commission believes either of these hospitals would be a more appropriate location.

SCI occupancy data for VISN 16 indicate that the Houston VAMC (446 miles from North Little Rock) has 40 inpatient SCI beds and an ADC of 30 (74 percent). The next closest medical centers with inpatient SCI beds are the Memphis (138 miles) and Dallas (329 miles) VAMCs. The Memphis SCI Center has 70 beds with an ADC of 53 (76 percent occupancy rate). The Dallas SCI Center has 30 beds with an ADC of 22 (73 percent occupancy rate).[373]

[372] Appendix Q, DNCP.
[373] VSSC KLF Menu Database, *Bed Control, Occupancy Rate,* as of the end of FY 2003.

VISN leadership indicated that a new SCI Center in VISN 16 might have a negative impact on inpatient units in Houston, Memphis, and Dallas based on referral patterns. Veterans' organizations voiced opposition to establishment of this center at North Little Rock, in favor of a more southern location collocated with a tertiary care VAMC.[374]

Commission Findings

1. SCI projection models indicate need for additional inpatient SCI beds in VISN 16.
2. SCI data for inpatient SCI Centers in Houston (446 miles), Memphis (138 miles), and Dallas (329 miles) indicate excess capacity.
3. North Little Rock does not have tertiary care services. However, the Little Rock Division and the Shreveport VAMC do provide tertiary care.
4. VISN leadership and veterans service organizations expressed concern about the placement of the SCI Center at North Little Rock, specifically due to the absence of tertiary care.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to establish a 30-bed SCI Center in VISN 16, but does not concur with locating it at North Little Rock.
2. The Commission recommends that VA further study where an SCI Center should be located, taking into consideration referral patterns and excess capacity at the closest SCI Centers.

VII Excess VA Property

DNCP Proposal

"Houston has the potential for an enhanced use lease cooperative arrangement with the private sector to construct a high-rise medical arts building."

DNCP Alternatives

None provided in the DNCP.

[374] VISN 16, Site Visit Report, Little Rock, AR, September 3, 2003.

Commission Analysis

In the Lower Central Market, only 55 percent of veterans meet the CARES travel guidelines for access to primary care. This market also identified a large increase in outpatient specialty care of 95 percent above the FY 2001 baseline by FY 2012 and 80 percent above baseline by FY 2022. An EUL was proposed to address the access gaps in primary and specialty care in the Houston area. Ed Tucker, VA Medical Center Director at Houston, testified that Houston has huge demands for services and that VA would need an additional 200,000 square feet of space. As a partial solution, the Houston VAMC is exploring a collaborative arrangement with its primary affiliate, Baylor College of Medicine, to build a 180,000 square foot ambulatory care center. Dr. Lynch, VISN 16 VISN Director, stated:

> The emphasis here is enhanced use. VA does not give up title to the land. We [use a] long-term 75-year lease. The scenario in Houston is the Baylor College of Medicine would build a large medical arts building with a couple of hundred thousand square feet of space for our use, which would cost us nothing but would be in the area of $40 million dollars… It's a benefit to the taxpayer.[375]

Commission Findings

1. There is an access gap and an increasing demand for outpatient services in the Houston area.
2. An EUL agreement with Baylor College of Medicine on the Houston VAMC campus would provide additional space to meet this demand.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for an EUL cooperative arrangement to construct a high-rise medical arts building at the Houston VAMC.
2. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

[375] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony form the Shreveport, LA, Hearing on August 27, 2003, pages 27-28.